

THIRD PART LIABILITY HEALTH INSURANCE INFORMATION

Michigan Department of Community Health

1. FIA Grantee Name			2. Date		
3. FIA Case Number	4. Co	Dist	Sec	Unit	Spec
5. Specialist Name			6. Specialist Phone Number ()		

Section 1 - RECIPIENT INFORMATION:

7. RECIPIENT NAME (Last First, Middle) <i>Use Additional Sheets if Necessary</i>	8. DATE OF BIRTH	9. RECIPIENT I.D. NUMBER	10. INJURY RELATED TO: (Check ONE)		
			WORK	MOTOR VEHICLE	OTHER
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 2 - IF WORK RELATED ILLNESS OR INJURY:

11. Date of Injury	12. Claim Number	16. Name of Employer at time of Illness or Injury		
13. Insurance Company Name		17. Employer Address (No. & Street)		18. Employ. Phone No. ()
14. Insurance Co. CITY	15. Insurance Co. Phone No. ()	19. City	20. State	21. ZIP Code

Section 3 - IF MOTOR VEHICLE ACCIDENT:

22. Date of Injury	23. Policy Claim Number	27. Determine and then check the highest priority vehicle insurance as numbered below.		
13. Insurance Company Name		<input type="checkbox"/> 1 - RECIPIENT <input type="checkbox"/> 3 - OWNER of Vehicle <input type="checkbox"/> 2 - Relative in Household <input type="checkbox"/> 4 - DRIVER of Vehicle		
14. Insurance Co. City	15. Insurance Co. Phone No. ()	28. Name of Insured Person		

Section 4 - If OTHER ACCIDENT OR INJURY

29. Date of Accident	30. Policy Claim Number	34. Name of Insurance Company Covering the Person or Premises		
31. Person who Caused Accident or who Owns the Premises		35. Insurance Company Address (No. & Street)		
32. Person / Owner City	33. Person / Owner Phone No. ()	36.	37. State	38. ZIP Code
39. Briefly Describe What Happened: _____ _____				

I certify that the above information is correct and complete to the best of my knowledge:

40. Signature	41. Phone No.	42. Specialist's Signature	Date
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